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Memorandum

Date: January 24, 2018

To: Commissioner Cassandra Tomarchio – Maryland Health Care Commission

From: Gerard J. Schmith
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Anne Arundel Medical Center Mental Health Hospital ("AAMHH") CON

On December 28, 2017, you requested that we review and comment on the financial feasibility and underlying assumptions of the proposed new Mental Health Hospital (AAMHH) to be located on property owned by Anne Arundel Medical Center approximately two miles from the main hospital campus adjacent to Pathways, a 40 bed substance abuse facility owned by Anne Arundel Medical Center. The proposed facility will include 4 floors and 56,236 square feet. The facility will be licensed as a private psychiatric hospital and will include space for the initially requested 16 beds with sufficient shelled space for either outpatient services or alternatively, an additional 16 beds.

Staff's review included an assessment of the original CON filed on March 26, 2016, and subsequent filings of response to completeness questions and revisions of the underlying financial projections submitted on April 6, 2017. Staff also reviewed AAMHH's responses to our questions regarding the financial projections and underlying assumptions submitted by AAMHH on December 11, 2017, and Baltimore Washington Medical Center's (BWMC) comments regarding AAMHH's responses to our questions, which BWMC submitted on December 28, 2017.

The remainder of this memo provides our comments regarding the AAMHH CON.

General Comments on Financial Feasibility

Data Reviewed

We reviewed the financial information contained within the CON application as well as other pertinent supplemental information associated with the CON process provided by AAMHH. The information submitted included projected financial data for the fiscal years ending June 30, 2019 through 2023. We also reviewed the underlying assumptions included in the CON and subsequently filed information.

Sources and Uses of Funds

The total projected cost of the project is $24,984,795. AAMHH is budgeting $16,080,433 for construction costs, $900,000 for major moveable equipment, $1,600,000 for contingencies, $4,167,870 in other capital costs including architect fees, site and infrastructure costs, and inspections and permits, $1,575,000 for IT integration, landscaping, and commissioning and testing, $511,492 for an inflation allowance, and $150,000 for financing costs.

AAMHH intends to finance the project by incurring $10,000,000 in debt and receiving a $14,984,795 cash contribution from its parent, Anne Arundel Medical Center.

Projected Volumes and Occupancy Levels

Included in Table 1 below are AAMHH's projected patient days and occupancy levels and partial hospitalization visits in the CON for FY 2019 through FY 2023:

Table 1 - Summary of Projected Patient Days, Occupancy Rates, and Partial Hospitalization Visits
Anne Arundel Medical Center Mental Health Hospital CON Projections

	2019	2020	2021	2022	2023
Patient Days	4,409	5,397	5,440	5,477	5,477
Occupancy Rate	75.5%	92.2%	93.2%	93.8%	93.8%
Partial Hospitalization Patients	4,699	5,679	5,718	5,758	5,799

Source: Financial information and projections submitted by AAMHH in the CON application.

Revenue Projections

We have reviewed the assumptions regarding the projections of patient revenue. Included in Table 2 below are the assumed inflated charges per patient day and per partial hospitalization visit for FY 2019 through FY 2023:

Table 2 – Projected Inflated Average Revenue Per Inpatient Day and per Partial Hospitalization Visit
Anne Arundel Medical Center Mental Health Hospital CON Projections

	2019	2020	2021	2022	2023
Projected Revenue Per:					
Patient Day	$1,412	$1,438	$1,465	$1,492	$1,519
(Excluding Physicians)	$1,320	$1,345	$1,370	$1,396	$1,423
Partial Hospitalization Visit	$416	$471	$480	$489	$498
(Excluding Physicians)	$403	$456	$465	$474	$483

Source: Financial information and projections submitted by AAMHH in the CON application and subsequently filed documentation.

The AAMHH projected inpatient revenue per patient day regulated by the HSCRC appears reasonable. However, AAMHH included physician revenue not regulated by the HSCRC, and, therefore, staff cannot comment on the reasonableness of the projected physician revenue.

The 13.2% projected increase in revenue per partial hospitalization visit between FY 2019 and FY 2020 ($416 to $471 reflected in Table 2) should be explained by AAMHH. The 13.2% increase may be related to an error in the utilization table submitted as part of the CON. In the CON, AAMHH projected 4,699 partial hospitalization visits during FY 2019 increasing by 21% to 5,679 in FY 2020. Patient days in the CON were projected to increase by 22% between FY 2019 and FY 2020. However, in AAMHH's responses to staff's question regarding outpatient rates, AAMHH stated that there would be 4,229 partial hospitalization visits in FY 2019, which would then indicate that AAMHH was projecting a 34% increase in outpatient volume between FY 2019 and FY 2020.

During the year ended June 30, 2017, the other private psychiatric hospitals in Maryland reported the following outpatient revenue and visits:

Table 3 – Average Revenue per Outpatient Visit
Maryland Private Psychiatric Hospitals
For the Year Ended June 30, 2017

Hospital	Outpatient Revenue	Outpatient Visits	Outpatient Revenue Per Visit
Sheppard Pratt	$16,581,207	64,900	$255
Adventist Behavioral Health	$4,783,750	15,232	$314
Brooklane	$1,516,207	3,729	$407
Totals	$22,880,984	83,861	$273
Median			$314

Source: Monthly Revenue and Statistics Reports submitted by hospitals to HSCRC. For Sheppard Pratt and Brooklane, outpatient visits were reported as Psychiatric Day Care Visits while Adventist Behavioral Health reported outpatient visits as Clinic visits.

The AAMHH projected outpatient revenue regulated by the HSCRC appears high. The projected 13.2% increase in projected revenue per visit between FY 2019 and FY 2020 would be more than the approximately 2% annual increase currently allowed under the Update Factor.. If the projected 4,229 visits included in AAMHH's response to staff's questions regarding the outpatient rates were the visits AAMHH meant to include in their projections, then the projected 34% increase in visits between FY 2019 and FY 2020 appears high given the assumed 22% increase in inpatient volumes during the same period.

Finally, the projected revenue per outpatient visit of $403 appears high based on the average private psychiatric hospital statewide rate for the year ended June 30, 2017 of $273, or the statewide median rate of $314 during the same period.

Staff has concerns that AAMHH may have projected outpatient revenue at a level 20% to 25% higher than would be reasonable given the current outpatient rates at other private psychiatric hospitals in Maryland. A 20% to 25% reduction in AAMHH's projected outpatient revenue would result in reduced net revenue of $400,000 to $500,000 annually.

AAMHH projected that charity write-offs would equal 1.5% of gross patient revenue and bad debts at 8.2% of gross patient revenue. This 9.7% uncompensated care provision appears high compared to

other Maryland psychiatric hospitals. AAMHH projected that contractual adjustments would equal 18.9% of gross patient revenue. As a Specialty Hospital, AAMHH does not fall under the Waiver provision whereby Medicare or Medicaid is required to reimburse hospitals at 94% of charges. AAMHH has projected Medicaid collections at 83% of charges and Medicare collections at 67% of charges.

Staff is concerned that AAMHH could be considered as part of the existing 40 bed Pathways facility operated by Anne Arundel Medical Center, which would trigger the Institutions for Mental Diseases (IMD) exclusion, potentially resulting in a large reduction in Medicaid reimbursement to less than the projected 83% of charges. In addition, if CMS were to view AAMHH as a 32 and not 16-bed hospital because the CON refers to shell space for an additional 16 beds as part of the constructions costs, Medicare reimbursement would likely be reduced as well.

Staff has attached a copy of the CMS guidelines that pertain to the reimbursement of services provided by IMDs.

AAMHH did not project any other operating or non-operating revenue.

Expense Projections

In its responses to staff's questions regarding projected expenses, AAMHH provided an analysis comparing its projected costs to the costs at other private psychiatric hospitals in Maryland on a per Equivalent Inpatient Patient Day (EIPD) basis. A summary of this analysis is provided below:

Table 4 – Comparison of Projected Cost per Equivalent Inpatient Patient Day (EIPD)
Anne Arundel Medical Center Mental Health Hospital CON Projections
versus other Maryland Private Psychiatric Hospitals

	AAMHH FY 2022 (16 beds)	Sheppard Pratt FY 2016 (414 beds)	Adventist Behavioral Health FY 2015 (107 beds)	Brooklane FY 2016 (66 beds)
Cost Per EIPD:				
Overhead	$350	$397	$375	$375
Inpatient Care	$349	$493	$335	$335
Clinic and Ancillary	$90	$100	$57	$129
Hospital Based Physicians	$96	$33	$0	$0
Information Services	$15	$45	$34	$19
Depreciation, Interest, Leases	$136	$110	$58	$59
Malpractice and Other	$2	$20	$53	$15
Total	$947	$1,179	$912	$944
Total Excluding Physicians	$851	$1,146	$912	$944
Total Excluding Physicians and Depreciation and Interest	$715	$1,036	$854	$885

Source: Financial information and projections submitted by AAMHH in the CON application and subsequent information. The information provided by AAMHH contained addition errors in the depreciation, interest and other expenses for the other private psychiatric hospitals which were corrected in the table above.

Staff has concerns that AAMHH's projected expenses may be understated for the following reasons:

1. When AAMHH projected revenue under the "inflated projected financial statements," they assumed that revenue would be inflated by approximately 6% (approximately 2% annually) between FY 2016 and FY 2019 and used these amounts as the projected FY 2019 revenue. However, when projecting operating expenses, AAMHH projected expenses expressed in FY 2016 dollars "uninflated." Furthermore, when AAMHH made comparisons of its inflated projected FY 2019 expenses to other private psychiatric hospitals it used expenses from Annual Reports filed by the other private psychiatric hospitals in FY 2015 and FY 2016 "uninflated."

2. Even after adjusting for the fact that there is a three-year timing difference in the expense comparisons to the other private psychiatric hospitals in Maryland, AAMHH's projected operating expenses per EIPD are significantly below what the other psychiatric hospitals are actually incurring.

3. AAMHH is a proposed 16-bed hospital with few economies of scale when compared to the other existing private psychiatric hospitals in Maryland, but AAMHH still projected operating expenses per EIPD well below what the other existing private psychiatric hospitals are actually incurring. Staff reviewed data for Medicare Cost Reports filed by private psychiatric hospitals throughout the country during Calendar Year 2015. For the 39 private psychiatric hospitals that reported having 16 licensed beds, the average Medicare per diem inpatient cost was $1,130, or 19.4% greater than AAMHH is projecting for FY 2019 based on FY 2022 volumes.

4. A major projected cost component at AAMHH is the projected hospital-based physician expense for which AAMHH has included projected revenue that would not be regulated by the HSCRC. By including these hospital-based physician costs in the cost comparison with the other private psychiatric hospitals in Maryland that do not include these costs, AAMHH appears less reasonable in the cost comparison with the other private psychiatric hospitals in Maryland.

In AAMHH's projected inflated financial statements, the projected costs per EIPD in FY 2022 were $992 compared to the $947 uninflated cost per EIPD shown in the table above. Reducing the projected $992 cost per EIPD for capital costs of $136 per EIPD and physician costs of $96 per EIPD would result in an estimated projected inflated adjusted cost per EIPD of $760 per EIPD. If AAMHH's FY 2022 projected inflated costs per EIPD excluding hospital-based physicians and capital costs were equal to Brooklane's actual FY 2016 costs excluding capital inflated by 2% per year for 6 years, AAMHH's projected costs would be approximately $1,700,000 more than what AAMHH has projected for FY 2022.

Summary

Staff is concerned about the construction of a 16-bed freestanding psychiatric facility, which may not have sufficient economies of scale to provide services effectively or efficiently. Given the New Model, global budgets, and the emphasis on reducing avoidable utilization and excess capacity, Staff questions whether it might not be more prudent to have these services provided in an existing acute care hospital, where the additional marginal costs could be significantly lower. Furthermore, if the new beds were located in an acute care facility, Medicare and Medicaid reimbursement would be 94% of charges rather than 67% and 83%, respectively, as estimated by AAMHH. Additionally, the IMD exclusion would not apply, thereby reducing the potential risk of future reductions in Medicaid reimbursement.

Staff is also concerned that outpatient revenue projected in the CON could be too high, and that operating expenses projected in the CON could be too low, based on comparisons to actual revenue and expenses incurred at other private psychiatric hospitals in Maryland. This combination of overstated revenue and understated expenses casts doubt on the projected profits in the CON. The HSCRC staff would closely analyze the projected revenue and expenses when setting the rates for this facility at the time it would open. However, Anne Arundel Medical System has shown a propensity to manage their operations appropriately in the past, and staff expects that they would continue to do so in the future.

4390. INSTITUTIONS FOR MENTAL DISEASES

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines

to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?

2. Is one chief medical officer responsible for the medical staff activities in all components?

3. Does one chief executive officer control all administrative activities in all components?

4. Are any of the components separately licensed?

5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?

6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;

2. The facility is accredited as a psychiatric facility;

3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);

4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and

5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient§s current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients

admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

4390.1 Periods of Absence From IMDs.--42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient.

The regulations contain a separate provision for individuals under age 22 who have been receiving the inpatient psychiatric services benefit defined in 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.